



**NAVIGATION MEDICAL CENTER** Jaime E. Duarte MD FAAFP  
Sonia P. Moncayo MD

3003 Navigation Blvd., Houston, TX 77003. Fax: 713-223-1571 Phone: 713-223-4466  
www.navigationmedical.com

**REGISTRATION FORM / HOJA DE REGISTRO**

Date / Fecha:	PCP / Médico primario:
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**PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE**

Patient / Paciente:	Marital status / Estado civil: (check one / seleccione uno)	
Last name / Apellido _____ First name / Primer nombre _____	<input type="radio"/> Single / Soltero	<input type="radio"/> Married / Casado
Preferred language / Idioma preferido: <input type="radio"/> English / Inglés <input type="radio"/> Spanish / Español	<input type="radio"/> Divorced / Divorciado	<input type="radio"/> Widow(er) / Viudo(a)

Gender / Género:	Birth date / Fecha de nacimiento:	Age / Años:	Address / Dirección:
<input type="radio"/> M <input type="radio"/> F	/ / m / m d / d y / a	_____	_____ City / Ciudad State / Estado ZIP Code

Ethnic / Etnia:	Race / Raza:
<input type="radio"/> Hispanic / Hispano <input type="radio"/> Not Hispanic / No Hispano	<input type="radio"/> White / Blanco <input type="radio"/> African american / Afro americano <input type="radio"/> Asian / Asiático

Social Security No. / No. del Seguro Social:	<b>EMPLOYMENT INFORMATION / INFORMACIÓN LABORAL</b>
Mobile phone No. / No. de móvil:	Occupation / Ocupación:
Home phone No. / No. Teléfono fijo:	Employer / Empleador:
E-mail address / Correo electrónico:	Contact phone No. / No. De contacto:

**INSURANCE INFORMATION / INFORMACIÓN DEL SEGURO**

Is this patient covered by insurance? / ¿Esta cubierto este paciente por un seguro médico?  
 No / No (Continue in 1. / Continuar en 1.)  Yes / Si (Continue in 2. / Continuar en 2.)

1. Person responsible for bill / Persona responsable de la cuenta:	Birth date / Fecha de nacimiento:	Contact phone No. / No. De contacto:
Last name / Apellido _____ First name / Primer nombre _____	/ / m / m d / d y / a	_____

2. Name of the **primary** insurance company / Nombre de la compañía de seguro médico **primario**:

Subscriber's name / Nombre del suscriptor:	Birth date / Fecha de nacimiento:	Policy No. / No. Poliza	Group No. / No. Grupo
Last name / Apellido _____ First name / Primer nombre _____	/ / m / m d / d y / a	_____	_____

Patient's relationship to subscriber / Relación del paciente con el suscriptor:  
 Self / Mismo  Spouse / Esposo (a)  Child / Hijo (a)  Other / Otro: \_\_\_\_\_

(If applicable / Si aplica) Name of the **secondary** insurance company / Nombre de la compañía de seguro médico **secundaria**:

Subscriber's name / Nombre del suscriptor:	Birth date / Fecha de nacimiento:	Policy No. / No. Poliza	Group No. / No. Grupo
Last name / Apellido _____ First name / Primer nombre _____	/ / m / m d / d y / a	_____	_____

Patient's relationship to subscriber / Relación del paciente con el suscriptor:  
 Self / Mismo  Spouse / Esposo (a)  Child / Hijo (a)  Other / Otro: \_\_\_\_\_

**IN CASE OF EMERGENCY / EN CASO DE EMERGENCIA**

Name of local friend or relative / Nombre de amigo o familiar:	Relationship to patient / Relación con el paciente:
_____	_____

Home phone No. / No. Teléfono fijo:	Mobile phone No. / No. de móvil:
_____	_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Navigation Medical Center or the Insurance Company to release any information required to process my claims.

La información anterior es verdadera bajo mi conocimiento. Autorizo a mi seguro pagar directamente al médico según beneficios pactados. Entiendo que soy financieramente responsable de cualquier balance. También autorizo a Navigation Medical Center o la compañía de seguros para suministrar toda la información necesaria para procesar los reclamos correspondientes.

_____ Patient / Guardian signature Firma del paciente o responsable	_____ Internal Use: Received/Reviewed by:
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**PAYMENT POLICY FORM**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**INSURANCE:** We participate in most insurance plans. If you are not insured by a plan, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit may be required until coverage is checked and payment is received. Knowing your insurance benefits is your responsibility. Contact your insurance to ask the questions you may have. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**CO-PAYMENTS AND DEDUCTIBLES:** All co-payments, coinsurances, and deductibles must be paid at the time of service. This arrangement is part of your and our contract with your insurance company. Failure on our part to collect co-pays, coinsurances, or deductibles is considered fraud. Please help us in upholding the law by paying your copayment, coinsurances, and deductibles at each visit.

**NON-COVERED SERVICES:** Please be aware that some or all of the services you receive may be non-covered or not considered medically necessary by your insurance. You must pay for these services.

**PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim.

**CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

**COVERAGE CHARGES:** If your insurance changes, please notify us ASAP, so we can make the appropriate changes to help you receive maximum benefit. If claim is not paid in 45 days, balance will be billed to you.

**NONPAYMENT:** If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Please, be aware that if a balance remains unpaid, we will refer you to a collection agency and you and your immediate family members may be discharged from this practice. You will be notified by regular and certified mail that you have 30 days to find alternative medical care. In this period, our physicians will only be able to treat you on an emergency basis.

**MISSED APPOINTMENTS:** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understood the payment policy and agree to abide by its guidelines.**

\_\_\_\_\_  
**PRINTED NAME**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**DEBIT/CREDIT CARD AUTHORIZATION**

I hereby authorize Navigation Medical Center and Spa to charge my debit/credit card for my or my dependent's future services not paid or not covered by the insurance company; that charge is based on the allowed amount determined by the insurance schedule fee. This authorization is intended only for medical services and cannot be used by other entities different than Navigation Medical Center. Navigation Medical Center is committed not to share the credit card information with any other parties. Navigation Medical Center agrees to keep this information as strictly CONFIDENTIAL. This authorization remains in full force and effect until the last debit entry has been processed.

\_\_\_\_\_  
**PRINTED NAME**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**



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## **PATIENT PRIVACY STATEMENT - HIPAA NOTICE OF PRIVACY PRACTICES**

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

#### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary info to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.** You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

#### **YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.



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Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

#### **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.**

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**PRINTED NAME**

**DOB**

**SIGNATURE**

**DATE**